State of Hawaii
Department of Health
Indoor and Radiological Health (IRH) Branch
Noise Section
591 Ala Moana Boulevard, Room 133
Honolulu, Hawaii 96813
(808) 586-4700

APPLICATION FOR COMMUNITY NOISE VARIANCE

Refer to "Guide to Application for Community Noise Variance" for instructions. Submit attachments if necessary. Application form and attachments must be submitted in triplicate.

1. Applicant Identification

   Company Name_____ Telephone_____

   Authorized Individual_____ Telephone_____

   Title_____

   Mailing Address_____

   _____

   _____

2. Type and purpose of activity

3. Location of activity

4. Time of activity

5. Estimated duration of construction activity (Specify dates)

   From_____ To_____

6. Schedule of activity (Submit as attachment)

7. Description of immediate impact area

8. List of equipment to be utilized (attach list if necessary)

9. Plans and procedures for the attenuation of noise emission emanating from the activity

10. Identify specific provisions of statutes or rules for which the variance is requested (include specific sections)

11. Description of alternatives to the proposed activity

12. Describe why the present or proposed activity cannot be altered to comply with applicable statutes or rules

13. Description of any adverse environmental effects which cannot be avoided

14. Discuss the relationship between short-term (temporary) use of the environment, and the maintenance and enhancement of long-term productivity

15. Discuss any irreversible and irretrievable commitments of resources which would be involved in the proposed activity

16. Discuss any possible impact from noise created by any proposed nighttime activity which may affect the immediate surrounding area

17. Discuss any plans or procedures for notification of people in the surrounding area of any planned nighttime activity

18. Describe the purpose of the project as relating to public interest

CERTIFICATION OF INDIVIDUAL AUTHORIZED TO ACT FOR APPLICANT

I, _____, certify that I have
Print Name
knowledge of the facts herein set forth and that the same are true and correct to the best of my knowledge and belief.

Signature_____

Date _____

FOR DEPARTMENT OF HEALTH USE ONLY

Date received _____

Variance Appl. Number _____

Variance Docket Number _____

Fee Paid _____ Receipt No. _____

Date Issued _____ Exp. Date _____